acceptable

POC #3

PRINTED: 03/12/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MADISON, TN 37115

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D 603	1200-08-25-.06 (1)(a)3. Administration (1) Each ACLF shall meet the following staffing and procedural standards: (a) Staffing Requirements: 3. An ACLF shall heve an identified responsible attendant who is alert end awake et all times and a sufficient number of employees to meet the residents ' needs, including medical services es prescribed. The responsible attendant end direct care staff must be et least eighteen (18) years of age and capable of complying with statutes end rules governing ACLFs. This Rule is not met as evidenced by: Based on medical record review, review of a facility Acuity Discharge Planning report, review of a police report, review of facility staffing schedules, observation and interview, the facility failed to provide sufficient staff to meet the needs for two residents (#2, #5) reviewed and twenty-two residents identified by the facility as having needs the facility was unable to meet. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an Acuity Discharge Planning report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed "...discovered in room by care	D 603	D603 Corrective action for residents affected: Resident #2 is no longer at this facility. He was discharged on 12-24-2011 to the hospital. Resident #5 is no longer at this facility. She was discharged on 2-14-2012 to a Nursing Home. The twenty two residents identified as having needs the facility are unable to meet, have been appropriately discharged to a higher level of care. Two of the identified residents are in the process of discharge with assistance from the Ombudsman. They are resident's #33 and #40. Resident #33 is scheduled to go to a nursing home. Resident #40 is scheduled to go to another facility. This will occur when the family completes financial arrangements and CHOICE's approval.	

Division of Health Care Facilities

Angela Hogan LNHA,EO Executive Director 4-5-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

STATE FORM 6899 GQB511 If continuation sheet 1 of 63

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D 603	Continued From page 1 attendant...bleeding from nose, ear, mouth, and jaw appeared to be swelling...had beat (resident) with cane..." Review of a police report dated December 24, 2011 revealed "...Victim (Resident #2)...eggravated assault...blunt object..." Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's (ED) office revealed Medication Supervisor #2, Care Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 returned to Resident #2's room at approximately 9:45 p.m. and CA #2 stated, "...was covered with blood...bleeding from jaw, gobs out of nose, coming from mouth (and) blood from right ear..." Telephone interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. revealed the resident was forgetful and she stated "...needed almost total care...typically 2-3 caregivers and me..." Interview with CA #2 on February 9, 2012 at 11:25 a.m. in the marketing office revealed her assignment on the evening of December 24, 2011 included seven totally dependent residents. Continued interview revealed three caregivers staffed the facility after 8:00 p.m., (12-24-12) after CA #5 went off duty at 8:00 p.m. Telephone interview with Police Detective #2 on	D 603	These two residents were assessed by a licensed nurse utilizing the Elmcroft assessment tool and their care needs were determined. The staff was in-serviced on what these two residents need in order to meet their specific staffing needs on March 30, 2012 by the Resident Service Director. <u>Other Residents that could potentially be affected:</u> Per the Elmcroft policy, residents will be provided sufficient staff to meet their needs. As stated in the regulations, 1200-08-25-.12 under Resident Records, page 32 number 4; An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy two (72) hours after admission; however in all reasonable opportunities a licensed nurse conducts the assessment per our policy. It is not acceptable practice for a	

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Addendum to D603

Complaint Survey March 1, 2012

Residents and Families complete a survey that is conducted by an independent third party annually. The Executive Director gets this information from these surveys and discusses with the other Directors. An action plan is submitted to the support center for follow up to ensure needs are met.

The facility conducts Resident Council Meetings monthly driven by the Healthy Lifestyles Director. Any concerns are followed up by the Directors to ensure needs are met.

The facility conducts monthly Family Meetings driven by the Executive Director. Any concerns are followed up by the Directors to ensure needs are met.

Suzanne Hogan LNHA, ED — 4-9-2012

Signature of Executive Director — Date

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D 603	Continued From page 2 February 7, 2012 at 10:05 a.m. revealed Resident #2 had expired, an autopsy had been performed and compilcations of blunt force trauma was the cause of death. Resident #5 was admitted to the facility on September 11, 2009 with diagnosas including Pick's Disease. Medical record review of a General Note dated August 1, 2011 revealed "...total assist with ADL's (activities of daily living)...slouched over in wheelchair...raposltioned several times, unabla to sit up...non-ambulatory, non weight-bearing..." Medical record review of a Chart Nota dated September 7, 2011 revealed "...was found on tha floor...hit tha left side of...head no redness or brulsing..." Review of an "Acuity Discharge Planning" report dated December 9, 2011 revealed "...total cara..." Medical record review of Chart Notes dated December 11, 2011 revealed, "Took to room after lunch and resident sild out of chair and wes on the floor...gash on left side of back of head...to (hospital). ..returned, spoke with Dr. (doctor) stated he put staples in...head otherwise...looked fina..." Medical record review of an Emergency Provider Record datad December 11, 2011 revealed "...Time (2:52 p.m.)...Historian: paramedics NH (nursing home) notes...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)..." Continued review revealed "...non-ambulatory at basaline...non-communicative at baseline...was unable to get a hold of staff...despite several. attempts. When spoka with Rn (Registered	D 603	Community Relations Director to conduct an assessment. A licensed nurse does an assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home dependent upon the residents needs as determined by the level of care assessment. On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living.	

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D 603	Continued From page 3 Nurse) at NH they were unable to prolvde any further historicel Information...stapled..." Revlew of a staffing schedule dated December 11, 2011 and interview with the RSD on February 1, 2012 at 1:48 p.m. In the ED's office revealed two Medical Technician's and a CA were scheduled to work the dey shift. The RSD stated "There had to be another caregiver but I don't see it." Revlew of Time Record Reports dated December 11, 2011 provided by the ED on February 8, 2012 revealed reports for the two medical technicians and no documentation regarding the scheduled CA or an RN. Observation on February 8, 2012 at 8:58 a.m. revealed Resident #5 was essisted byTechnician #2 into a sitting position and the facility's Quality Services Manager (a Licensed Practical Nurse) administered medication to the resident with a spoon. Continued observation revealed Medical Technician #2 physically lifted the resident and placed the resident onto the bed. Review of an Acuity Discharge Plenning Report dated December 9, 2011 provided by the ED on February 7, 2012 revealed the facility determined twenty-six residents including Residents #2 end #5 required "Immediate Move-out." Continued review revealed the following: Resident #2: needs secure unit Resident #5: Hospice; Total Care Resident #6: Total Care Resident #7: 104 years old; hospice; total care Resident #8: Non-ambulatory; total care Resident #9: Wound on heel Resident #24: Total Care	D 603	<u>Measures and systematic changes to prevent recurrence:</u> The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by the Quality Service Manager to monitor the Resident Services Director and Executive Director. This meeting is to ensure the facility can meet the acuity levels of the residents. A Resident Service Coordinator position was added on February 16, 2012 to be responsible for scheduling with a primary focus of staffing. The staffing is determined by the number of residents being serviced and their individual care plan needs. The Resident Service's Coordinator reports directly to the Resident Service Director. The Resident Service Director will review a sample of the care plan's one time per week for the next 6 weeks and ongoing as needed.	

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0 603	Continued From page 4 Resident #25: Non-ambuletory Resident #26: Non-amb (non embulatory), two person transfer; - Hospice Resident #27: Needs secure unit Resident #28: Totel Care... Resident #29: Total Care... Resident #30: Two person tranfer Resident #31: Confused; non-ambulatory Resident #32: Total Care Resident #33: Blind; Total Cere Resident #34: Wanders; needs secure unit Resident #37: Total Care Resident #38: Confused; total care Resident #39: Non-ambulatory Review of a letter from the facility end dated January 18, 2012 revealed "...Notice of Discharge and Transfer...(Resident #39)...has needs that cannot be safely and effectively met in the Community (assisted living facility)..." Review of letters from the fecility and dated Jenuary 19, 2012 revealed "...Notice of Discharge and Transfer...(Residents #8, # 24, #25, #28, #27, #28, #29, #30)...has needs that cannot be safely and effectively met in the Community..." Review of letters from the facility and dated Jenuary 20, 2012 revealed "...Notice of Discherge end Transfer...(Residents #34, #40-Resident #40 was not included on the facility provided Acuity Discharge Planning report dated December 9, 2011)...Notice of Discherge and Transfer...hes needs that cannot be safely and effectively met in the Community..." Review of the fecility's current census dated Jenuary 30, 2011 revealed eighteen of the residents identified by the facility in the report	0 603	The Executive Director and Resident Services Director have a system of checking the staffing model to ensure it is sufficient to meet the acuity needs of the residents. Labor hours are reviewed Monday through Friday with Executive Director, Resident Service Coordinator and Resident Service Director to ensure adequate staffing is utilized. This system is monitored weekly by reporting during the regional operations call with the Regional Director of Operations and Quality Service Manager <u>Corrective Action:</u> The level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home, and labor hours will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident	

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D 603	Continued From page 5 dated December 9, 2011 remained in the facility. interview with the Chief Operating Officer on January 31, 2012 at 9:00 a.m. in the ED's office revealed the facility had twenty-two current residents for whom the facility was unable to provide the required care and confirmed the facility had insufficient staff to meet the needs of the residents. C/O: #28393, #29126	D 603	Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12
D 609	1200-08-25-.06 (1)(b)3. Administration (1) Each ACLF shall meet the following staffing and procedural standards: (b) Policies and Procedures: 3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement. This Rule is not met as evidenced by: Based on medical record review, review of facility investigation documentation, review of ambulance service documentation, review of police investigation documentation, review of facility policy and interview, the facility failed to notify the police and fully investigate an allegation of assault according to the facility's abuse policy for one resident (#2) of twenty residents	D 609	<u>D609</u> <u>Corrective action for residents affected:</u> The licensed nurse or shift supervisor will contact the appropriate authorities, to include the police if applicable, in the event of an emergency requiring such action. Resident #2 was discharged to a hospital on 12-24-2011. Resident #14 was discharged to a Behavioral Health Facility on 12-24-2011.	

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D 609	Continued From page 6 reviewed. The findings included: Resident #2 was admitted to the facility on October 12, 2010 with diagnoses including Dementia, Hypertension, and Depression. Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed "...discovered in room by Care Attendant...bleeding from nose, ear, mouth, and jaw appeared to be swollen. (Resident #2) stated that roommate (Resident #14) was trying to kill (Resident #2) and had beat (Resident #2) up. Cane was found that belonged to (Resident #14) it was bloody and broke into (in two)...Resident sent to ER (emergency room)..." Medical record review of an undated, untimed Chart Note revealed, "(Resident #14) was questioned by (Medication Supervisor #2)...stated that (Resident #14) did not hit (Resident #2), that (Resident #2) had hit...self." Review of an Ambulance Service Report dated December 24, 2011 revealed a call was received at 10:06 p.m.; the ambulance arrived on the scene at 10:21 p.m., transported the resident at 10:39 p.m. and included "...Chief Compiaint: Fall with Bleeding from head..." Continued review revealed a line was drawn through the chief complaint and included "...(10:35 p.m.) Pulse 56 Blood Pressure 206/92...Bleeding, facial trauma, hand trauma...Pt (patient) was beaten by ...roommate with a cane...AOS (arrived on scene) to find...(Resident #2) sitting in facility w/c (wheelchair)...severe swelling to L side of face, nose deformed...L (left) eye swollen, contusions and abrasions to L side of face ...pupils pinpoint and non reactive...abrasions to top side of both	D 609	<u>Other Residents that could potentially be affected:</u> Executive Director and Resident Services Director In-serviced the entire staff March 20, 21 and 22, 2012 on incident reporting, the completion of the incident report and chain of command, thorough investigation of alleged abuse, including those incidents which require notification to the TN Department of Health, Adult Protective Services and other authorities including the police if necessary. Executive Director and Resident Services Director In-serviced the entire staff March 20, 21 and 22, 2012 on those resident's that may request a sitter service. We currently do not have any resident's utilizing a sitter service at this time. The in-service included that sitters will be required to have a background check completed by the hiring agency, the abuse registry check, drug screen and evidence of non-communicable disease/TB screening.	

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D 609	Continued From pege 7 hands ...transported...to (Hospital #1)..." Medical record review of an Emergency Room Raport (Hospital #1) dated December 24, 2011 ravealed "...the patient was at...assisted living facility ...where (Resident #2) was assaulted by...roommate...beeten about tha face with a cana...has dementia...Is a fall risk...chronic falls at baseline. Therefora ...wears a helmat...helmet was apparently on..,when...actually beat..so hard thet the cane broke...sevare treuma to...face...left auricular hematoma with small skin tear on the superior portion of the auricle...large abrasion at...maxilla/inferior orbital region with a large skin tear and a moderate emount of swelling and ecchymosis (brulsing)...0.5 cm (centimeter) skin tear over...nasal bridga...edematous nose with a deformity, clotted nasal blood bilatarelly...uppar and lower lip edeme with some abrasions...clotted blood present (in mouth)...Both...hands show defensive wounds...punctura wouhd on the dorsum of tha right hand ...comminuted bilateral nasal bone fractures and a large left facial ...hematoma...obviously in a severe amount of pain with multiple fractures. I do not feel like (Resident #2) is safe to be discharged home with concern for an obstructing of...airway...Disposition: (Hospital #2)..." Medical record review of a History and Physical (Hospital #2) dated December 25, 2011 revealed "...was attacked by...roommate and hit in the face several times with e cane...also sustained soft tissue damage to...right hend while trying to defend...self from the blows...bilateral nasal fractures ...left periorbital hematoma with swollen and tender nose as well as a laceration of the upper lip...CT (computed tomography)...comminuted bileteral nasal bona	D 609	Measures and systematic changes to prevent recurrence: The Executive Director and Resident Services Director have been in-serviced on the proper completion of an abuse investigation including notifying the appropriate authorities by the Quality Services Director, March 19, 2012. Executive Director and Resident Services Director in-serviced the entire staff March 20, 21 and 22, 2012 on incident reporting, the completion of the incident report and chain of command, thorough investigation of alleged abuse, including those incidents which require notification to the TN Department of Health, Adult Protective Services and other authorities including the police if necessary. Executive Director and Resident Services Director in-serviced the entire staff March 20, 21 and 22, 2012 on those resident's that may [illegible] sitter service. We	

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D 609	Continued From page 8 fractures...extensive paranasal left periorbital and left facial masticator space hamatoma with involvement of the left messeter muscle...Impression: 1. Blunt facial trauma secondary to assault...3. Lip laceration status post repair...7. Dementia..." Medical record review of a Consultation Report (Hospital #2) dated December 25, 2011 revealed "...was transferred to (Hospital #2) for otolaryngology evaluation...Due to...end stage Alzheimer's...very dependant under the care of caregivers...We will ice left side of...face...next 48 hours ...Internal lip laceration that was repaired in several places with...suture after injection with 1% Lidocaine...will allow the swelling of...face and nose to resolve over the next 5-7 days and at that time will evaluate for functional and cosmetic deformity..." Medical record review of a Discharge Summary (Hospital #2) dictated December 27, 2011 revealed "...Condition at Discharge:...completely alert and oriented to...self and not to the place and time, which is probably related to chronic dementia...(spouse)...notified about the plan for discharging. However, the patient wants to be in another facility and never wanted to get back to the previous one..." Medical record review of a prescription signed by the physician responsible for the Discharge Summary and dated December 27, 2011 revealed "Lortab 5/325 one or two po q6h prn pain (by mouth every six hours as needed for pain)." Review of facility investigation documentation dated December 24, 2011 on January 31, 2012 revealed "...Time 10:00 p.m...Primary Injury/Unusual Occurrence Possible Head Injury Skin Breakdown Bruise Cuts/Scrapes ...Was the	D 609	currently do not have any resident's utilizing a sitter service at this time. The in-service included that sitters will be required to have a background check completed by the hiring agency, abuse registry check, drug screen and evidence of non-communicable disease/ TB screening. The Resident Service Director or Executive Director will input incident report data into the company online incident reporting system within 72 hours of an incident for tracking and trending. The Director of Compliance reviews this report monthly. Corrective Action: The incident reporting system tracking and trending summary will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining	

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D 609	Continued From page 9 incident witnessed? No...Discovered by (Care Associate #2) Investigation Observations: Resident was found in room bleeding from ear, mouth, jaw appeered to be swelling,..stated that...roommate (Resident #14) hit...with...cane ...Hospitalized? Yes...Suspicion of Abuse: No..." Continued review revealed the report was signed by Medication Supervisor #2 and was not signed by the "General Manager." Review of police department investigation documentation dated December 24, 2011 revealed "...Offense Description: Aggravated Assault...Weapon Code: blunt object...Dispatch was called by an EMT (emergency medical technician)...that...(Resident #2) had been beaten up by...roommate ...went out to (facility)...spoke with personnel...(Care Associate #2) was the careteker who found (Resident #2)...(Care Associate #2) stated while doing room checks she found (Resident #2) sitting in the common area with the injuries...officers were then informed that (Resident #2) hed gone into the room of (Resident #14) and tried to wake (resident #14) up. (Resident #14) then became very angry and violent and began beating (Resident #2) with cane...No call from (facility) was ever attempted about the incident and contact was not made with the facility until officers went to the location after being at (hospital)...(Medication Supervisor #2) was the manager on duty during the incident...When officers went to the incident location the crime scene had been cleaned up by the center staff..." Continued review revealed Medication Supervisor #2 was not interviewed. Review of the facility's Abuse Policy dated August 1, 2011 revealed "...Each resident has the right...of a full, equitable investigation in the event	O 609	Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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D 609	Continued From page 10 of resident abuse...The purpose of this policy is to: Ensure the resident's right to a safe and secure environment. Provide e means of reporting and investigation elleged abuse of a resident. Comply with residents rights and the law...Definitions of Abuse:...Any action, deliberate or negligent that results in bodlly harm...may include...assault...The Executive Director will: Determine if an investigation is werranted after revlewing the facte...Obtein relevant information from...All witnesses...The process shall be completed in as short e time es possible...Report...shall contain: A statement of the facts (i.e., verbatim statements...Depending on the nature and the severity of the elleged abuse, the Executive Director is required to report the incident(s)...could be as follows: Police: the decision to notify the police will be based on the: Evidence Extent of the injuries...Law in the normal course of events, the police will be notified of any elleged essault unless there ere very strong reasons to the contrary. As soon as reasonable grounds exist to believe that a criminal offense against e resident may have taken place, the investigator shall notify the police..." Interview with the Executive Director (ED) on January 31, 2012 at 9;00 a.m. In the ED's office reveeled no knowledge of en allegation of resident abuse or resident-to-resident altercation in the past three months; the ED stated "If there had been would heve necessitated an incident report." Interview with the Chief Operating Officer (COO) on January 31, 2012 et 9:00 e.m. in the ED's office revealed no knowledge of an allegation of resident abuse or resident-to-resident eltercation in the past three months. Interview with the COO	D 609		

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D 609	Continued From page 11 on January 31, 2012 at 10:00 a.m. revealed he was aware of the facility's investigation documentation dated December 24, 2011 and the facility had made inquiries regarding regulatory requirements regarding the injuries to Resident #2 prior to January 31, 2012. Interview with the Quality Services Manager on January 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roommates for the resident and she stated "It was obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone...(Resident #2) was on list to move out." Interview with the Quality Service Manager on February 1, 2012 at 1:10 p.m. in the ED's office revealed the facility had statements from all staff who worked the evening/night of December 24, 2011. Continued interview revealed statements from all staff who provided care to Resident #2 on other shifts on December 24, 2011 had been obtained and the investigation documentation was not available to the State Agency. Telephone interview with the Senior Vice President of Resident Services (conference call included the Executive Director and Quality Services Manager) on February 1, 2012 at 2:40 p.m. in the Executive Director's office revealed "...We understand severity of (the) situation...At this point in time no statements from employees signed and dated, just statements taken by our lawyers... no information that any care staff aware (Resident #14) had aggressive tendencies..." Interview with Care Associate (CA) #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2 had not	D 609		

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D 609	Continued From page 12 witnessed the beating of Resident #2 and included "...don't think i've been inserviced on abuse since I've been here...If saw resident to resident altercation report it stop it ...have not seen any of that since I've been here..." Continued interview revealed CA #2 had never seen Resident #2 hit anyone and CA #2 stated "...confused most all the time...December 24, 2011...in bed asleep about 7:30-8:00 p.m. Beck again...probably 9:45 (p.m.). Got to...room. Cheir against (the)door, (the) door was cracked. (Resident #2) was standing there. I asked what are you doing. I reached and moved (the) chair (Resident #2) standing there all bloody on the shirt, all over (resident's) face...on pents. Little bit of blood on doorway of (Resident #14's) room. (Resident #2) was covered with blood. I ren and got nurse (Medication Supervisor #2) (saw blood on doorway after got nurse). We sat (resident) in chair...bleeding from jaw, gobs out of nose, coming from mouth, blood from right ear. Majority (injuries) on right side. (Resident #14) was laying in the bed, didn't see any blood on (Resident #14). (Resident #14) was awake. Another ceregiver (Medication Technician -MT#3) came and noticed a stick beside (Resident #14's) bed. He esked (Resident #14) did you hit (Resident #2) with this cane. (Resident #14) said no (Resident #2) broke it and i took it from (Resident #2) ...(MT #3) esked, 'Where's tha other half of the cane?' and (Resident #14) said it was on the other side of the bed. Thare was blood on the end of the cane where you hold it. Didn't see any blood on end that was broken off but I didn't examine it. I took the cane and held it. I leid it on the med (medication) cart, both pieces. There was wood chips on the floor in (Resident #14's) room...(Resident #2) had pajama pants on with white tee-shirt. Gobs of blood on white tee-shirt. (I) saw no blood on (Resident #14's) bed. 911	D 609		

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D 609	Continued From page 13 was called. The embulance came. They asked (Resident #14) "what happenad to this man. What did you do to...(Resident #2) and (Resident #14) said I didn't do anything. (Resident #2) did it to...saif. There's no way possible...did it to...self. No avidence (Resident #2) had fallen ...That day before supper (Resident #14) said 'I wish the hell (Resident #2 would) quit following me ...Tha ambulance man said, 'he did not do this to ...saif. (Resident #14) did this...You all need to call tha police...police called me at 1:30 a.m. after I got home and asked ma what I saw. I don't know who called the police." Intarview with MT #3 on Fabruary 1, 2012 at 4:40 p.m. in the ED's offica revealed he had not witnessed the beating of Resident #2 and included "(Resident #2) had a history of wandering and ramoving (own) clothes..." Continued interview revealed, "...notifiad by cara attendant...(Resident #2) was bleeding. I noticed blood in (Resident #14's) room. Ona piece of the cane was under the bed and other piece was visible between the bad and dresser...blood on entrance of (Resident #14's) room and from where cane was at. (Resident #2) was in living room in wheelchair. Blood from entrance to (Resident #14's) room and drops to where cane was broke off...after finding cane we made a report. I called the ambulance...(Resident #2) had helmet on when I saw...left ear mouth and nosa bloody. Nose punctured had blood coming from it...Ambulance arrived, asked (Resident #14) 'Dude...what happened' ...That day (Resident #2) was following (Resident #14) end (Resident #14) said quit following ma..." Telephone interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. revealed she had not witnessed the baating of Resident #2, the	D 609		

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D 609	Continued From page 14 resident was forgetful and she stated "...needed almost total care...no anger issues just little annoying person. (The) type person to be in your way...I went to room...was standing there with care attendant..had blood on... face...said, 'He was trying to kill me end I charted that in the notes...I called the embulance...There was no nurse there...The police came. I did not call the police. They had conversation with me about why I didn't call them. I didn't see it as a crime. The policeman told me nose hed been broke and considered as assault...In room (Resident #14) (was) in bed calm, cool, collected. I did see drops of blood on (Resident #14's) floor. (MT #3) brought it to my attention...(Resident #14) could converse in full sentences. (Resident #2) communicated in very simple terms..." Interview with the Resident Services Director (RSD) on February 2, 2012 at 2:35 p.m. In the Executive Director's office reveeled the RSD was unable to identify the sitter assigned to Resident #2 on December 24, 2012. Telephone interview with the manager of a facility contracted sitter service on Februery 2, 2012 et 2:38 p.m. reveeled e sitter employed by the service was assigned to Resident #2 on the evening of December 24, 2011 until approximately 9:00 p.m. Interview with the Resident Services Director (RSD) on February 7, 2012 at 10:34 e.m. revealed the RSD had not interviewed any residents regarding the injuries to Resident #2 on December 24, 2011. Telephone interview with Police Detective #1 on February 7, 2012 et 10:55 a.m. revealed "They did not call the police. I can tell you that. They	D 609		

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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D 609	Continued From page 15 walk into the room. They didn't mention the cane until days later...got (anonymous) Crime Stopper's tip regarding the cene...(Hospital #1) celled the police. Police respond go to facility. Scene had been cleened up. They didn't tell the officer thay hed the murder weapon...did eutopsy. Complications (of) blunt force trauma's cause of death..." Interview with the Executive Director on February 7, 2012 at 8:50 a.m. in the marketing office reveeled she did not know who called the police and she stated "...Once residents were out of building would have expected staff to call the police...think I got to work the 27th. I went to the room. I asked if we had cleaned the room. There was no mess...I didn't see blood. Housekeeping had not been in. I know they did not clean...I did get statement from (Care Associate #2) on the 27th , It was verbal and I wrote it ...(CA #2) did not sign it...did not interview any residents. Didn't know eny residents wera aware until the day before the newspaper release...I learned aboul (Resident #15) the day the peper came out (Resident # 15 had been to room and saw Resident #2 before the resident was transported to the hospital according to the newspaper story referred to by the ED)..." Continued interview confirmed the facility failed to notify the police and fully investigate an alleged assault according to the facility's abuse policy. Interview with the ED on February 7, 2012 at 10:50 a.m. in tha marketing office revealed the facility's sitter policy required a sitter to sign in at the front desk on arrival and sign out on departure. Continued interview revealed the sitter for Resident #2 on December 24, 2011 had not signed in and/or out as required by facility policy.	D 609		

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D 609	Continued From page 16 Interview with the ED on February 8, 2012 at 9:50 a.m. in Resident #2's former room revealed the ED spoke to Medication Supervisor #2 after the resident was beaten on December 24, 2011 and she stated, "...had put cane in plastic bag and took it to the med (medication) room..." Interview with the Senior Vice President of Resident Services on February 10, 2012 at 2:20 p.m. revealed the facility had failed to notify Adult Protective Services of the alleged assault, and confirmed the facility had failed to implement the facility's abuse policy. C/O: #29126	D 609		
D 629	1200-08-25-.06 (5)(c)1. Administration (5) Infection Control (c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include: 1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each resident contact if hands are not visibly soiled; This Rule is not met as evidenced by: Based on review of facility policy, review of Centers for Disease Control and Prevention (CDC), observation and interview, the facility	D 629	D629 Corrective action for residents affected: The facility will use gloves and follow hand hygiene for residents #17 and 18. Medication Technician #1 will use proper hand hygiene. Other Residents that could potentially be affected: Hand sanitizers were mounted on the walls throughout the facility on February 17, 2012 to ensure proper hygiene for residents, staff	

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D 629	Continued From page 17 failed to use gloves and adhere to a hand hygiene program for two residents (#17, #18) of twenty residents reviewed. The findings included: Review of facility policy titled "Employee Hand Washing" dated August 1, 2011 revealed "...Policy: Employees must wash hands under the following circumstances:...After blowing nose, coughing, or sneezing...Before and after preparing or serving meals, drinks...Before and after having direct contact with residents...After removing gloves, which should be worn as a standard precaution when in direct contact with...resident equipment...etc...The community (facility) should provide adequate warm running water, soap, paper towels in hand washing areas. If there is no hand washing facilities or supplies available...should make available to the employee waterless hand washing supplies to be used according to the manufacturer's recommenations. The employee should wash hands with soap and water as soon as feasible..." Observation on February 1, 2012 from 11:25 a.m. to 11:35 a.m. revealed Medicine Technician (Med Tech) #1 coughed into her ungloved hands, touched the notebook of Medication Administration Records, and placed a bottle of medication into the medication cart. Continued observation revealed Med Tech #1 placed the medication cart into the elevator, pressed the elevator button for the first floor, coughed into the the left ungloved hand, coughed into the right ungloved hand, prepared medication, poured water from a pitcher into a cup, and entered Resident #17's room without washing her hands. Continued observation revealed the Med Tech #1 held the medication cards, touched both of	D 629	and visitors. Housekeepers have a schedule for ensuring they are kept full. Housekeepers also have a schedule for ensuring soap and hand towels are available in resident apartments. **Measures and systematic changes to prevent recurrence:** The Housekeeping/Maintenance Director will check all soap dispensers and hand sanitizer dispensers weekly to ensure they are adequately filled. Staff was in-serviced by the Executive Director and Resident Services Director on March 20, 21 and 22, 2012 to include proper hand hygiene according to the facility policy. Hand Washing signs are posted in the kitchen and in employee areas, instructing employees of the necessity and proper method of washing hands. The Resident Services Director will observe proper hand hygiene one time per week for six weeks and ongoing as needed. This will be recorded on a spreadsheet to track compliance.	

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D 629	Continued From page 18 Resident #17's hands and assisted the resident to push the medication into a cup. Continued observation revealed Med Tech #1 returned to the medication cart and did not wash her hands. Continued observation revealed Med Tech #1 coughed into her right ungloved hand, turned pages in the Medication Administration Records, obtained a bottle of medication and shook it, opened the narcotic drawer and obtained a medication card. Continued observation revealed Med Tech #1 poured water from the pitcher into a cup, entered the room of Resident #18, poured liquid medication into a cup, and assisted the resident to take the medication. Continued observation revealed Med Tech #1 returned to the medication cart after assisting Resident #18 and did not wash her hands. Interview with Med Tech #1 on February 1, 2012 at 11:35 a.m. in the corridor next to Resident #18's room revealed the med tech was unaware of any unacceptable practice during the observation. Continued interview revealed the practice was to cough into her shirt, and Med Tech #1 stated "...I ran out of gloves while ago. Most of the time I wash hands between patients and have hand sanitizer to help out...no sanitizer right now..." Continued interview revealed the med tech was aware not washing the hands and/or not using gloves could spread infection. Interview with the Quality Services Manager on February 10, 2012 at 1:07 p.m. in the marketing office confirmed the facility failed to utilize standard precautions including a hand hygiene program for Residents #17 and #18 on February 1, 2012. C/O: #28393	D 629	**Corrective Action:** The spreadsheet for tracking hand hygiene will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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D 713	1200-08-25-.07 (7)(e)1. Services Provided (7) An ACLF shall provide personal services as follows: (e) Each ACLF shall provide each resident with at least the following personal services: 1. Protective care; This Rule is not met as evidenced by: Based on medical record review, review of facility investigation documentation, review of police investigation documentation, review of facility policy, review of a facility staffing schedule, review of an Acuity Discharge Planning report and interview, the facility failed to provide protective care for three residents (#2, #5, #20) of twenty residents reviewed. The findings included: Resident #2 was admitted to the facility on October 12, 2010 with diagnoses including Dementia, Hypertension, and Depression. Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed "...discovered in room by Care Attendant...bleeding from nose, ear, mouth, end jaw appeared to be swollen. (Resident #2) stated that roommate (Resident #14) was trying to kill (Resident #2) and had beat (Resident #2) up. Cane was found that belonged to (Resident #14) it was bloody and broke into (in two)...Resident sent to ER (emergency room)..." Medical record	D 713	D713 Corrective action for residents affected: Residents number 2, 14 and 5 have been discharged from the facility. Resident #20 will be provided protective care according to the facility abuse policy by in-service training the staff. This was completed on March 20, 21, and 22, 2012 to include verbal instruction and to provide understanding of the different types of abuse. The policy has been posted by the time clock for easy access/review. Staff will be in-serviced on abuse upon hire, and annually. Other Residents that could potentially be affected: Executive Director and Resident Services Director In-serviced the entire staff, March 20, 21 and 22, 2012 on responding appropriately in a crisis situation. This was accomplished through verbal instruction and examples of situations that would be determined as a crisis situation.	

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D 713	Continued From page 20 review of an undated, untimed Chart Note revealed, "(Resident #14) was questioned by (Medication Supervisor #2)...stated that (Resident #14) did not hit (Resident #2), that (Resident #2) had hit...self." Medical record review of an Emergency Room Report (Hospital #1) dated December 24, 2011 revealed "...the patient was at...assisted living facility ...where (Resident #2) was assaulted by...roommate...beaten about the face with a cane...has dementia...actually beat...so hard that the cane broke...severe trauma to...face...left auricular hematoma with small skin tear on the superior portion of the auricle...large abrasion at...maxilla/inferior orbital region with a large skin tear and a moderate amount of swelling and ecchymosis (bruising)...0.5 cm (centimeter) skin tear over...nasal bridge...edematous nose with a deformity, clotted nasal blood bilaterally...upper and lower lip edema with some abrasions...clotted blood present (in mouth)...Both...hands show defensive wounds...puncture wound on the dorsum of the right hand ...comminuted bilateral nasal bone fractures and a large left facial ...hematoma...obviously in a severe amount of pain with multiple fractures. I do not feel like (Resident #2) is safe to be discharged home with concern for an obstructing of...airway...Disposition: (Hospital #2)..." Medical record review of a History and Physical (Hospital #2) dated December 25, 2011 revealed "...was attacked by...roommate and hit in the face several times with a cane...also sustained soft tissue damage to...right hand while trying to defend...self from the blows...bilateral nasal fractures ...left periorbital hematoma with swollen and tender nose as well as a laceration of the	D 713	The Maintenance Director assessed all door locks on March 29, 2012 to ensure they are in proper working order. Measures and systematic changes to prevent recurrence: Executive Director and Resident Services Director in-serviced the entire staff, March 20, 21 and 22, 2012 on responding appropriately in a crisis situation. As per the standards, a member of management will see every resident daily. The Maintenance Director will do preventative maintenance on door locks monthly to ensure they are in proper working order. Staff has been in-serviced by the Executive Director, March 9, 2012 on reporting any physical plant issues to the Maintenance Director via the work order form and via telephone in the event of an emergency. If unable to reach the Maintenance Director, the staff has been instructed to follow	

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D 713	Continued From page 21 upper lip...CT (computed tomography)...comminuted bilateral nasal bone fractures...extensive paranasal left periorbital and left facial masticator space hematoma with involvement of the left masseter muscle...Impression: 1. Blunt facial trauma secondary to assault...3. Lip laceration status post repair...7. Dementia..." Medical record review of a Discharge Summary (Hospital #2) dictated December 27, 2011 revealed "...Condition at Discharge:...completely alert and oriented to...self and not to the place and time, which is probably related to chronic dementia...(spouse)...notified about the plan for discharging. However, the patient wants to be in another facility and never wanted to get back to the previous one..." Review of facility investigation documentation dated December 24, 2011 on January 31, 2012 revealed "...Time 10:00 p.m...Primary Injury/Unusual Occurrence Possible Head Injury Skin Breakdown Bruise Cuts/Scrapes ...Was the incident witnessed? No...Discovered by (Care Associate #2) Investigation Observations: Resident was found in room bleeding from ear, mouth, jaw appeared to be swelling...stated that...roommate (Resident #14) hit...with...cane ...Hospitalized? Yes...Suspicion of Abuse: No..." Continued review revealed the report was signed by Medication Supervisor #2, and not signed by the "General Manager." Review of police department investigation documentation dated December 24, 2011 revealed "...Offense Description: Aggravated Assault...Weapon Code: blunt object...Dispatch was called by an EMT (emergency medical technician)...that...(Resident #2) had been beaten	D 713	the chain of command for notifying the appropriate management staff. **Corrective Action:** The facility abuse policy and protocol for reporting, along with the system for physical plant/ maintenance issues that need immediate attention will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

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D 713	Continued From page 22 up by...roommate ...went out to (facility)...spoke with personnel...(Care Associate #2) was the caretaker who found (Resident #2)..." Review of the facility's Abuse Policy dated August 1, 2011 revealed " ...The purpose of this policy is to: Ensure the resident's right to a safe and secure environment...Definitions of Abuse:...Any action, deliberate or negligent that results in bodily harm...may include...assault..." Review of the staffing schedule and interview with the Resident Care Coordinator (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's office revealed Medication Supervisor #2, Care Associate (CA)#2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA #2 on February 9, 2012 at 11:25 a.m. in the marketing office revealed her assignment on the evening Resident #2 was beaten included seven totally dependent residents. Continued interview revealed three caregivers staffed the facility on December 24, 2011 after CA #5 went off duty at 8:00 p.m. Interview with the Executive Director (EO) on January 31, 2012 at 9:00 a.m. in the EO's office revealed no knowledge of an allegation of resident abuse or resident-to-resident altercation in the past three months. Interview with the Chief Operating Officer (COO) on January 31, 2012 at 9:00 a.m. in the EO's office revealed no knowledge of an allegation of resident abuse or resident-to-resident altercation in the past three months. Interview with the Quality Services Manager on	D 713		

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D 713	Continued From page 23 Januery 31, 2012 at 10:47 a.m. in the ED's office revealed the resident's family had requested a change of roommates for the resident (unspecified dete) and she stated "It wes obvious (Resident #14) had beaten (Resident #2). As soon as the company assumed ownership (August 1, 2011) we had assessed everyone... (Resident #2) wes on list to move out." Interview with CA #2 on February 1, 2012 at 3:00 p.m. in the Executive Director's office revealed CA #2 hed not witnessed the beating of Resident #2, and included "...don't think i've been inserviced on abuse since I've been here...If saw resident to resident altercation report it stop it ...have not seen any of thet since I've been here..." Continued interview reveeled the resident was confused, and CA #2 stated, "...confused most ell the time...December 24, 2011...in bed asleep about 7:30-8:00 p.m. Beck again...probably 9:45 (p.m.). Got to...room. Cheir agalnst (the)door, (the) door was cracked. (Resident #2) was standing there. I asked what are you doing. I reached end moved (the) chair (Resident #2) standing there ell bloody on the shirt, all over (resident's) face...on pants. Little bit of blood on doorway of (Resident #14's) room. (Resident #2) was covered with blood. I ran end got nurse (Medication Supervisor #2) (saw blood on doorway after got nurse). We sat (resident) in chair...bleeding from jaw, gobs out of nose, coming from mouth, blood from right ear. Majority (injuries) on right side. (Resident #14) was laying in the bed, didn't see any blood on (Resident #14). (Resident #14) was awake. Another caregiver (Medication Technician -MT#3) came and noticed a stick beside (Resident #14's) bed. He esked (Resident #14) did you hit (Resident #2) with this cane. (Resident #14) said no (Resident #2) broke it and I took it from (Resident	D 713		

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D 713	Continued From page 24 #2) ...(MT #3) asked, 'Where's the other half of the cane?' and (Resident #14) said it was on the other side of the bed. There was blood on the end of the cane where you hold it. Didn't see any blood on end that was broken off but I didn't examine it. I took the cane and held it. I laid it on the med (medication) cart, both pieces. There was wood chips on the floor in (Resident #14's) room...(Resident #2) had pajama pants on with white tee-shirt. Gobs of blood on white tee-shirt. (I) saw no blood on (Resident #14's) bed. 911 was called. The ambulance came. They asked (Resident #14) "what happened to this man. What did you do to...(Resident #2) and (Resident #14) said I didn't do anything. (Resident #2) did it to...self. There's no way possible...did it to...self. No evidence (Resident #2) had fallen ...That day before supper (Resident #14) said 'I wish the hell (Resident #2 would) quit following me..." Interview with MT #3 on February 1, 2012 at 4:40 p.m. in the ED's office revealed he had not witnessed the beating of Resident #2 and included "(Resident #2) had a history of wandering and removing (own) clothes...That day (Resident #2) was following (Resident #2) and (Resident #14) said quit following me..." Telephone interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. revealed she had not witnessed the beating of Resident #2, Resident #2 was forgetful and she stated "...needed almost total care...no anger issues just little annoying person. (The) type person to be in your way...I went to room...was standing there with care attendant..had blood on... face...said, 'He was trying to kill me and I charted that in the notes...I called the ambulance...There was no nurse there...The police came, I did not call the police. They had conversation with me about why	D 713		

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D 713	Continued From page 25 I didn't call them. I didn't see it as a crime. The policeman told me nose had been broke and considered as essault...in room (Resident #14) (was) in bed calm, cool, collected. I did see drops of blood on (Resident #14's) floor. (MT #3) brought it to my attention...(Resident #14) could converse in full sentences. (Resident #2) communicated in very simple terms..." Telephone interview with the manager of e sitter service on February 2, 2012 at 2:35 p.m. revealed a sitter employed by the service was assigned to Resident #2 on the evening of December 24, 2011 until approximately 9:00 p.m. Interview with the Executive Director (EO) on February 2, 2012 at 2:48 p.m. revealed the facility failed to obtain abuse registry or background information for the resident's sitter. Telephone interview with Police Detective #1 on February 7, 2012 at 10:55 a.m. revealed "They did not call the police. I can tell you that. They walk into the room. They didn't mention the cane until days later...got (anonymous) Crime Stopper's tip regarding the cane...(Hospital #1) called the police...They didn't tell the officer they had the murder weapon...did autopsy. Complications (of) blunt force trauma's cause of (Resident #2's) death..." Interview with the Executive Director on February 7, 2012 at 8:50 a.m. in the marketing office revealed she did not know who called the police and she stated, "...Once residents were out of building would have expected staff to call the police...did not interview any residents..." Interview with the ED on February 7, 2012 at 10:50 a.m. in the marketing office revealed the	D 713		

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D 713	Continued From page 26 sitter for Resident #2 on December 24, 2011 had not signed in on the sign-in sheet as required by facility policy. Review of the staffing schedule and interview with the Resident Care Coordinator (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's office revealed Medication Supervisor #2, Care Associate #2, Care Associate #5, and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA #2 on February 9, 2012 at 11:25 a.m. in the marketing office revealed her assignment on the evening Resident #2 was beaten included seven totally dependent residents. Continued interview revealed three caregivers staffed the facility on December 24, 2011 after Care Associate #5 went off duty at 8:00 p.m. Interview with the facility's Quality Services Manager (QSM) on January 31, 2012 at 10:47 a.m. in the Executive Director's office revealed the resident's family had requested a change of roommates for the resident and confirmed the facility had failed to provide protective care for Resident #2 on December 24, 2011. The QSM stated "...It was obvious (Resident#14) had beaten (Resident #2)..." Resident #5 was admitted to the facility on September 11, 2009 with diagnoses including Pick's Disease. Review of an Acuity Discharge Planning report dated December 9, 2011 revealed, "...total care..."	D 713		

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D 713	Continued From page 27 Medical record review of a Chert Note dated September 7, 2011 revealed "...wes found on floor...hit...head...no redness or bruising..." Medical record review of Chert Notes dated December 11, 2011, revealed, "Took to room after lunch and resident slid out of chair and was on floor...gash on left side of head...to hospital...returned, spoke with Dr. (doctor) stated he put staples in...heed..." Medical record review of en Emergency Provider Report dated December 11, 2011 revealed "...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)...non-ambulatory at baseline...non-communicative at baseline...stapled..." Observation on February 8, 2012 at 8:58 e.m. revealed Medical Technician (MT) #2 assisted the resident to end held the resident in an upright sitting position. The facility's Quality Services Manager (Licensed Practical Nurse) administered medication to the resident. Continued observation reveeled MT #2 physically lifted the resident and placed the resident onto the bed. Review of an Acuity Discherge Planning Report dated December 9, 2011 revealed, "...total care..." Interview with the ED on February 1, 2012 at 2:10 p.m. revealed the facility determined on December 9, 2011 the resident's needs could not be met in the facility. Continued interview confirmed the facility falled to provide protective care for Resident #5 on December 11, 2011.	D 713		

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D 713	Continued From page 28 Resident #20 was admitted to the facility on February 1, 2011 with diagnoses including Chronic Obstructive Pulmonary Disease and Pacemaker. Review of facility investigation documentation dated December 27, 2011 which was signed, dated and provided by the Executive Director (ED) on February 10, 2012 revealed the ED was the first person notified, the resident's physician was not notified and included "...I heard someone banging on a door. I came upon (resident) trapped in (resident's) room due to a lock malfunction. I broke the lock off and opened (resident's) door. (Resident) stated...had been trapped for 15 hours and two people came to (resident's) door and left to get help and never returned." Review of facility investigation documentation dated December 27, 2011 and initialed by the ED revealed "...oriented to time and place incident of (resident) door being locked for full shift... (Medical Technician #3) states (resident) was locked in...room and I reported it to (Med Tech #5)...(Med Tech #5) states...door was locked...she tried to open the door but was unable to get it open...time line shows: ...Making rounds at 10:45 pm (p.m.) found...door locked...reported...all (staff) went upstairs to try and open door...(Resident) was in (resident's) room 14 or 15 hours..." Review of facility investigation documentation signed by Med Tech #5 and dated December 30, 2011 revealed "...(resident) said (resident) could not open...door this was about 12:00 midnight...I attempted to help...by rambling (ramming) the door with my shoulder and still could not get the door open...told (resident) that I would tell .	D 713		

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D 713	Continued From page 29 (Maintenance Director) when he gets in...When I saw (Maintenance Director) it was when I was clocking out to go home...but he had already open (opened) the door..." Continued review revealed, "...I am not to let this heppen again ...this is a fire hazzard (hazard)." Review of facility investigation documentation signed by Medical Technician #3 and dated February 10, 2012 revealed" ...wes locked in...room...I ...notify (notified) other employees who was (were) working at that time during the incident. I try (tried) unlocking the door, raming (remming) the door, and even try (tried) to pick the lock..." Interview with the Maintenance Director on February 9, 2012 at 3:35 p.m. in the marketing office revealed on December 27, 2011 at 8:30 a.m. the Maintenance Director was upstairs changing a light bulb and he stated, "...I heard beating on a door...lock was altered in some way. (Resident) said (resident) had bent lever down and door wouldn't open...(resident) said...In there all night...told me people had come while door was not working properly and hed said they would come back end never did...I told (ED) that morning...I broke the lock off to gain access to the room and repaired (lock) that morning." Observation end interview with the resident on February 9, 2011 at 3:47 p.m. In the front entry lounge revealed the resident seated in a chair, a wheelchair was beside the resident, and the resident had lived at the facility for approximately three to four months. Continued interview revealed the resident used the wheelchair as a walker and the resident stated, " ...was locked inside. Gotta think. I was actually locked inside...I couldn't get out. I went to the door and it wouldn't	D 713		

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D 713	Continued From page 30 open...didn't use the call light. Someone told me it didn't work...locked in the biggest part of the day...during night into early morning...I just felt trapped. I knocked on the door trying to get attention..." Interview with the ED and the Vice President of Resident Services on February 10, 2012 at 10:30 a.m. in the marketing office revealed the facility had investigated and substantiated that resident was locked in the resident's room on December 27, 2011. Continued interview confirmed the facility failed to provide protective care to Resident #20 on December 27, 2011. C/O: #29126, #28393	D 713		
D 714	1200-08-25-.07 (7)(a)2. Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with at least the following personal services: 2. Safety when in the ACLF; This Rule is not met as evidenced by: Based on medical record review, review of a facility Acuity discharge Planning Report, review of a police report, review of facility staffing schedules, review of a Job Description, review of a list of facility employees, and interview, the facility failed to provide personal safety for one resident (#2) of twenty residents reviewed and failed to safely administer medications to two	D 714	D714 Corrective action for residents affected: Resident #2 was discharged from the facility on December 24, 2011. Medications will be safely administered by licensed nurses to residents #19, 35, 41 and 42. Residents number 5,30,31,34 and 36 have been discharged from the facility.	

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D 714	Continued From page 31 residents (#5, #19) of twenty residents reviewed and eight residents identified by the facility (#5, #30, #31, #34, #35, #38, #41, #42) of forty-two sampled residents on three of three shifts. The findings included: Resident #2 was admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an "Acuity Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "...discovered in room by care attendant...bleeding from nose, ear, mouth, and jaw appeared to be swelling...had beat (resident) with cane..." Review of e police report dated December 24, 2011 revealed, "...Victim (Resident #2)...aggravated assault...blunt object..." Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's (ED) office revealed Medication Supervisor #2, Care Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 returned to Resident #2's room at approximately 9:45 p.m. and CA #2 stated, "...was covered with	D714	**Other Residents that could potentially be affected:** Per Elmcroft policy, residents will be given medication, if assistance is needed, by licensed personnel to ensure personal safety. It is the practice and policy of Elmcroft that all medication be prepared and administered by the same licensed nurse. **Measures and systematic changes to prevent recurrence:** The Executive Director and Resident Services Director in-serviced staff on medication administration, March 20, 21 and 22, 2012 to ensure instruction was given that only licensed personnel may administer medications to residents. Additional licensed nurses were hired covering first and second shifts, to administer medication to the residents who require assistance. During times when licensed nurses are not at the facility, there will be on call nurses to cover. The	

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D 714	Continued From page 32 blood...bleeding from jaw, gobs out of nose, coming from mouth (and) blood from right ear..." Telephone Interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. reveeled the resident was forgetful and she stated "...needed almost total care...typically 2-3 caregivers and me..." Interview with CA #2 on February 9, 2012 at 1.1:25 a.m. In the marketing office revealed her assignment on the evening of December 24, 2011 included seven totally dependent residents. Continued Interview revealed three caregivers staffed the facility after 8:00 p.m., (12-24-12) after CA #5 went off duty at 8:00 p.m. Telephone Interview with Police Detective #2 on February 7, 2012 at 10:05 a.m. revealed Resident #2 had expired, en autopsy had been performed end complications of blunt force treuma was the cause of death. Review of an Aculty Discharge Planning Report dated December 9, 2011 provided by the ED on February 7, 2012, revealed the facility determined twenty-six residents including Residents #2 and #5 required "Immediate Move-out." Continued review revealed the following: Resident #2: needs secure unit Resident #5: Hospice; Total Care Resident #6: Total Care Resident #7: 104 years old; hospice; total care Resident #8: Non-ambulatory; total care Resident #9: Wound on heel Resident #24: Total Cere Resident #25: Non-ambulatory Resident #26: Non-amb (non embulatory), two person transfer - Hospice	D 714	licensed nurse scheduled to be on call will be responsible for clinical coverage. The on call schedule is completed by the Resident Service Director monthly. The licensed personnel will be assigned as a charge nurse during the shift they are covering to be held accountable for staff supervision. The Resident Services Director or Pharmacy Consultant will supervise the licensed nurses and will monitor for compliance by observing medication passes and evaluating performance. This will be done one time per quarter for two quarters, and annually going forward, documented on a spreadsheet to be reported to the Quality Service Manager for review. The Executive Director and Resident Services Director have been in-serviced on the proper completion of an abuse investigation including notifying the appropriate authorities by the Quality Services Director, March 19, 2012.	

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	TNPL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MADISON, TN 37115

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
D 714	Continued From page 33 Resident #27: Needs secure unit Resident #28: Total Care... Resident #29: Total Cere... Resident #30: Two person tranfer Resident #31: Confused; non-ambulatory Resident #32: Total Care Resident #33: Blind; Total Care Resident #34: Wanders; needs secure unit Resident #37: Total Care Resident #38: Confused; total care Resident #39: Non-ambulatory Review of e letter from the fecility and dated January 18, 2012 revealed, "...Notice of Discharge and Transfer...(Resident #39)...has needs that cannot be safely and effectively met in the Community (assisted living facility)..." Review of letters from the facility and dafed January 19, 2012 revealed, "...Notice of Discharge and Transfer...(Residents #8, # 24, #26, #26, #27, #28, #29, #30)...has needs thet cannot be safely and effectively met in the Community..." Revlew of letters from the facility and dafed January 20, 2012 revealed "...Notice of Discharge and Transfer...(Residents #34, #40)...Notice of Discharge and Transfer...has needs that cannot be safely end effectively met in the Community..." Review of the fecility's current census dated January 30, 2011 revealed eighteen of the residents identified by the facility in the report dated December 9, 2011 remained in the facility. Interview with the Chief Operating Officer on January 31, 2012 at 9:00 a.m. in the ED's office revealed the facility had twenty-two current	D 714	Executive Director and Resident Services Director in-serviced the entire staff March 20, 21 and 22, 2012 on incident reporting, the completion of the incident report and chain of command, thorough investigation of alleged abuse, including those incidents which require notification to the TN Department of Health, Adult Protective Services and other authorities including the police if necessary. Residents # 2, 5, 6, 7, 8, 9, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 37, 38 and 39 have been discharged from the facility. Per the Elmcroft policy, residents will be provided sufficient staff to meet their needs. As stated in the regulations, 1200-08-25-.12 under Resident Records, page 32 number 4; An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy two (72) hours	

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D 714	Continued From page 34 residents for whom the facility was unable to provide the required care and confirmed the facility had insufficient staff to meet the needs of the residents. Review of a list of employees dated February 2, 2012 and provided by the Executive Director on February 2, 2012 revealed six employees were designated as Medication Technicians. Review of a Job Description dated January 1, 2004 revealed, "Position Title: Certified Nursing Assistant (CNA)/Resident Assistant/Medication Technician/Personal Care Aide ...Position Summary Provides personal care for Residents under direction of nursing staff ...No medication errors on any medication administered or supervised ...Supervisory Responsibilities This job has no direct supervisory responsibilities. Essential Duties ...The requirements listed below are representative of the knowledge, skill, and or ability required ...Verifies identity of Resident receiving medication, checks the MAR (medication administration record) to assure correct medication is being given, and records time of administration ...administers medication to assure all medication is being taken as directed ...Observes Resident to detect response to specified types of medications ...Qualifications Education: High School or GED preferred ...Medication Technician certification where required." Telephone interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. revealed " ...I pass out meds (medications) and manage staff on my shift ..."	D 714	after admission; however in all reasonable opportunities a licensed nurse conducts the assessment per our policy. It is not acceptable practice for a Community Relations Director to conduct an assessment. A licensed nurse does an assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home dependent upon the residents needs as determined by the level of care assessment.	

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D 714	Continued From page 35 Telephone interview with Medication Supervisor #1 on February 7, 2012 at approximately 9:45 a.m. revealed " ...pass Lortabs, Ambien, pretty much regular narcotics..." Interview with Medication Technician (MT) #1 on February 7, 2012 at 1:45 p.m. in the first floor medication room reveeled MT #1 worked first shift and MT #1 stated "I do fingersticks, give eye drops, eer drops, inhalers..." Interview with MT #4 on February 7, 2012 at 3:38 p.m. in the first floor corridor revealed "...no difference in a med tech and med tech supervisor ...I do eye drops for (Resident #41, #42, #30, #19)..." Interview with MT #2 on February 7, 2012 et 2:10 p.m. in the first floor medication room revealed the medications he administered to Resident #18 on February 7, 2012 included Hydrocodone and Metformin (medication that effects blood sugar levels). Continued interview revealed he did not know what Metformin was, end he stated, " ...I don't know what side effects to watch for." Continued interview revealed he monitored for dizziness/faintness after administration of Warfarin (medication that effects the ability of blood to clot) end he stated " ...If I notice (adverse side effects) I report to my supervisor (MT #1)." Further interview revealed "I give eye drops to (Resident #19)..." Interview with MT #1 on February 10, 2012, at 9:20 a.m. in the first floor corridor revealed she hed administered insulin injections to sampled Resident #35 and she steted "...most recently a couple of months ego...but i have given injections. I know I'm not supposed to."	D 714	On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living. Corrective Action: Medication pass tracking and the facility abuse policy and protocol for reporting and the level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home, and labor hours will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-

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D 714	Continued From page 36 Interview with Care Associate (CA) #4 on February 10, 2012 at 10:00 a.m. in the first floor corridor revealed she had witnessed Medical Technicians administer medications into residents' mouths, inject insulin. Continued interview revealed CA #4 was unable to identify a specific medical technician she had witnessed administer insulin injections. She stated "...You mean in their stomachs...A lot of them give insulin shots." Interview with MT #2 on Febrery 10, 2012 at 11:25 a.m. in the first floor medication room revealed he had administered insulin to two residents discharged from the facility (Residents #36, #31). MT #2 stated "...I have poured meds (pills) into residents' mouths (Residents #42, #34), nobody else, not aware (I am) not supposed to...(former EO) who told me (I) did not need certification to pass meds ...new company said a nurse was supposed to be passing meds..." A request for certification of the facility's Medical Technicians was made to the Executive Director on February 8, 2012 at 9:13 a.m. Interview with the Executive Director on February 8, 2012 at 9:13 a.m. in the marketing office confirmed the facility failed to administer medications by qualified staff. The ED stated "They are not (certified). They're to be certified to my understanding. Do you have a program...If I have a Med Tech on the cart (medication) they're not to be doing patient care. If a nurse is on the cart the med tech can do patient care after that med pass. That's the way I staff in this building." Observation and interview with MT #2 on February 8, 2012 between 8:40 a.m. and 9:00 a.m., revealed the following: MT #2 had medication for sampled Resident #5 in a	D 714		

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D 714	Continued From page 37 medication cup. Medical record review of the Medication Administration Record revealed MT #2 had initialed as administered the following medications: Effexor XR, Depakote Sprinklee 125 milligrams (mg), Heidol 0.5 mg., and Keppra 500 mg. (The contents of Depakote and Effexor capsules were emptied into the medication cup.) MT #2 walked approximately fifty feet toward the resident's room and stated "Welt e minute." Continued interview revealed MT #2 did not know what Effexor ER, Depekote Sprinkles, or Keppra were. At 8:50 e.m., the facility's Quality Services Manager (QSM) arrived at the medication cart and MT #2 walked away. At approximetely 8:58 a.m., MT #2 retumed and stated "I got (the QSM-a Licensed Practical Nurse) cause not supposed to crush meds and (Resident #5) refuses a lot end (QSM) will have to give them." At approximately 8:59 a.m., MT #2 assisted the resident to an upright sitting position and the QSM administered the medication. Continued observation revealed the QSM did not initiel the administration of the resident's medication. Interview with the facility's Quelity Assurance Manager (QSM) on February 9, 2012 at 9:48 a.m. in the marketing office reveeled it was not safe to administer medicetions another person prepared and confirmed the QSM administered medications she had not prepared to sampled Resident #5 on Februery 8, 2012. C/O #:28393, #29126	D 714		
D 716	1200-08-25-.07 (7)(a)4. Services Provided (7) An ACLF shall provide personal services as follows: (a) Each ACLF shall provide each resident with	D 716		

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D 716	Continued From page 38 at leest the following personal services: 4. The ability and readiness to intervene if crises arise; This Rule is not met as evidenced by: Besed on medical record review, review of a police report, review of facility staffing schedules, review of facility investigation documentation, observation, and interview, the facility failed to appropriately respond for one resident (#2) following a physical essault; failed to timely intervene for one resident (#20) locked inside a room; facility failed to provide sufficient staff to meet the needs for two residents (#2, #5) reviewed of twenty residents reviewed. The findings included: Resident #2 wes admitted to the facility on June 30, 2011 with diagnoses including Dementie. Review of an "Acuity Discharge Planning" report dated December 9, 2011 revealed the resident required care necessary in a secured unit (facility not licensed for secured unit). Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "...discovered in room by care attendant...bleeding from nose, ear, mouth, and jaw appeared to be swelling...had beat (resident) with cane..." Review of a police report dated December 24, 2011 revealed, "...Victim (Resident	D 716	D716 Corrective action for residents affected: The facility will appropriately intervene with ability and readiness in the event of a crisis. Resident #2 is no longer at this facility. He was discharged on 12-24-2011 to the hospital. Resident #14 is no longer at this facility. He was discharged on 12-24-2011 to a Behavioral Health Facility. Resident #5 is no longer at this facility. She was discharged on 2-14-2012 to a Nursing Home. Resident #20 will have protection provided as stated in the individualize service plan as well as following the standards, which state that a member of management will see every resident daily.	

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D 716	Continued From page 39 #2)...aggravated assault...blunt object..." Review of the staffing schedule and interview with the Resident Services Director (RSD) on February 1, 2012 at 1:48 p.m. in the Executive Director's (ED) office revealed Medication Supervisor #2, Care Associate (CA) #2, CA #5 and Medical Technician #3 were scheduled to work the evening shift on December 24, 2011. Interview with CA) #2 on February 1, 2012 at 3:00 p.m. in the ED's office revealed CA #2 observed Resident #2 asleep between 7:30 p.m. and 8:00 p.m. Continued interview revealed CA #2 returned to Resident #2's room at approximately 9:45 p.m. and CA #2 stated, "...was covered with blood...bleeding from jaw, gobs out of nose, coming from mouth (and) blood from right ear..." Telephone interview with Medication Supervisor #2 on February 2, 2012 at 1:55 p.m. revealed the resident was forgetful and she stated "...needed almost total care...typically 2-3 caregivers and me..." Interview with CA #2 on February 9, 2012 at 11:25 a.m. in the marketing office revealed her assignment on the evening of December 24, 2011 included seven totally dependent residents. Continued interview revealed three caregivers staffed the facility after 8:00 p.m., (12-24-12) after CA #5 went off duty at 8:00 p.m. Telephone interview with Police Detective #2 on February 7, 2012 at 10:05 a.m. revealed Resident #2 had expired, an autopsy had been performed and complications of blunt force trauma was the cause of death.	D 716	<u>Other Residents that could potentially be affected:</u> Staff will be provided an individualized service plan by the supervisor each shift that will ensure that all the residents' needs are met. The initial service plan is completed on the day of move in. Changes to the service plan are made monthly and if there are changes in condition. This is completed by the Resident Service Director who provides it to the direct care staff. The Resident Services Director will determine with 30 day assessments the level of assistance that each resident requires. The service plan is checked by the licensed nurse or supervisor of the shift to ensure assignments are properly being carried out. This information is reported to the Resident Service Director. Per the Elmcroft policy, residents will be provided sufficient staff to meet their needs. As stated in the	

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D 716	Continued From page 40 Resident #20 wes admitted to the facility on February 1, 2011 with diagnoses including Chronic Obstructive Pulmonary Disease and Pacemaker. Review of facility investigation documentation deted December 27, 2011 which wes signed, dated end provided by the Executive Director (ED) on February 10, 2012 revealed the ED was the first person notified, the resident's physician was not notified and included, "...I heerd someone banging on e door. I came upon (resident) trepped in (resident's) room due to a lock malfunction. I broke the lock off end opened (resident's) door. (Resident) stated...had been trapped for 15 hours and two people came to (resident's) door and left to get help and never returned." Review of facility investigation documentation dated December 27, 2011 and initieled by the ED revealed, "...oriented to time and place incident of (resident) door being locked for full shift.. (Medical Technician #3) states (resident) was locked in...room and I reported it to (Med Tech #5)...(Med Tech #5) states...door was locked...she tried to open the door but was unable to get it open...time line shows: ...Making rounds at 10:45 pm (p.m.) found...door locked...reported...ell (staff) went upstairs to try and open door...(Resident) was in (resident's) room 14 or 15 hours..." Review of facility investigation documentation signed by Med Tech #5 and dated December 30, 2011 revealed, "...(resident) said (resident) could not open...door this was about 12:00 midnight...I attempted to help...by rambling (ramming) the door with my shoulder and still could not get the door open...told (resident) that I would tell	D 716	regulations, 1200-08-25-.12 under Resident Records, page 32 number 4; An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy two (72) hours after admission; however in all reasonable opportunities a licensed nurse conducts the assessment per our policy. it is not acceptable practice for a Community Relations Director to conduct an assessment. A licensed nurse does an assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home dependent upon the residents needs as determined by the level of care assessment.	

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D 716	Continued From page 41 (Maintenance Director) when he gets in...When I saw (Maintenance Director) it was when I was clocking out to go home...but he had already open (opened) the door..." Continued review revealed, "...I am not to let this happen again ...this is a fire hazzard (hazard)." Review of facility investigation documentation signed by Medical Technician #3 and dated February 10, 2012 revealed, "...wes locked in...room...I ...notify (notified) other employees who was (were) working at that time during the incident. I try (tried) unlocking the door, reming (ramming) the door, and even try (tried) to pick the lock..." Interview with the Maintenence Director on February 9, 2012 at 3:35 p.m. in the marketing office revealed on December 27, 2011 at 8:30 a.m., the Maintenance Director wes upstairs changing a light bulb and he stated, "...I heard beating on a door...lock was altered in some way. (Resident) said (resident) hed bent lever down and door wouldn't open...(resident) seid...In there all night...told me people had come while door was not working properly and had seid they would come back and never did...I told (ED) thet morning...i broke the lock off to gain access to the room and repaired (lock) that morning." Observation and interview with the resident on February 9, 2011 at 3:47 p.m. in the front entry lounge revealed the resident seated in a chair, a wheelchair was beside the resident, and the resident had lived at the facility for approximately three to four months. Continued interview revealed the resident used the wheelchair as a walker and the resident stated "...was locked inside. Gotta think. I was actually locked inside...I couldn't get out. I went to the door and it wouldn't	D 716	On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living. **Measures and systematic changes to prevent recurrence:** The Regional Director of Operations will monitor the Executive Director weekly via an operations overview call to ensure sufficient staff is in place to meet the needs of the residents. The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by the Quality Service Manager to monitor the Resident Services Director and Executive Director. This meeting is to ensure the facility can meet the acuity levels	

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D 716	Continued From page 42 open...didn't use the call light. Someone told me it didn't work...locked in the biggest part of the day...during night into early morning...I just felt trapped. I knocked on the door trying to get attention..." Interview with the ED and the Vice President of Resident Services on February 10, 2012 at 10:30 a.m. in the marketing office revealed the facility had investigated and substantiated that resident was locked in the resident's room on December 27, 2011. The ED stated "I can prove time frame from at least 6:30 p.m. until 6:30 a.m...The tumbler had fallen in (lock)." Continued interview confirmed facility staff neglected to timely intervene to provide access to/from Resident #20's room on December 27, 2011. Resident #5 was admitted to the facility on September 11, 2009 with diagnoses including Pick's Disease. Medical record review of a General Note dated August 1, 2011 revealed "...total assist with ADL's (activities of daily living)...slouched over in wheelchair...repositioned several times, unable to sit up...non-ambulatory, non weight-bearing..." Medical record review of a Chart Note dated September 7, 2011 revealed "...was found on the floor...hit the left side of...head no redness or bruising..." Review of an "Acuity Discharge Planning" report dated December 9, 2011 revealed "...total care..." Medical record review of Chart Notes dated December 11, 2011 revealed, "...to room after lunch and resident slid out of chair and was on the floor...gash on left side of back of head...to	D 716	of the residents. A Resident Service Coordinator position was added on February 16, 2012 to be responsible for scheduling with a primary focus of staffing. The staffing is determined by the number of residents being serviced and their individual care plan needs. The Resident Service's Coordinator reports directly to the Resident Service Director. The Resident Service Director will review a sample of the care plan's one time per week for the next 6 weeks and ongoing as needed. The Executive Director and Resident Services Director have a system of checking the staffing model to ensure it is sufficient to meet the acuity needs of the residents. Labor hours are reviewed Monday through Friday with Executive Director, Resident Service Coordinator and Resident Service Director to ensure adequate staffing is utilized. This system is monitored weekly by reporting during the regional operations call with the Regional	

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D 716	Continued From pege 43 (hospital)...returned, spoke with Dr. (doctor) stated he put staples in...head otherwise...looked fine..." Medical record review of an Emergency Provider Record dated December 11, 2011 revealed "...Time (2:52 p.m.)...Historian: paramedics NH (nursing home) notes...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)..." Continued review revealed "...non-ambuletory et beseline...non-communicative at baseline...was unable to get a hold of staff...despite several attempts. When spoke with Rn (Registered Nurse) at NH they were unable to proivde any further historical information...stapled..." Review of a staffing schedule dated December 11, 2011 and Interview with the RSD on February 1, 2012 at 1:48 p.m. in the ED's office revealed two Medical Technician's and a CA were scheduled to work the day shift. The RSD stated "There had to be another caregiver but I don't see it." Review of Time Record Reports dated December 11, 2011 provided by the ED on February 8, 2012 revealed reports for the two medical techniciens and no documentetion regarding the scheduled CA or an RN. Observation on February 8, 2012 at 8:58 a.m. revealed Resident #5 was assisted byTechnician #2 into a sitting position and the facility's Quality Services Maneger (a Licensed Practical Nurse) administered medication to the resident with a spoon. Continued observation revealed Medical Technician #2 physically lifted the resident and placed the resident onto the bed. Review of an Acuity Discharge Planning Report	D 716	Director of Operations and Quality Service Manager **Corrective Action:** The facility abuse policy and protocol for reporting and the level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home, and labor hours will be revlewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN PL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 716	Continued From page 44 dated December 9, 2011 provided by the ED on February 7, 2012 revealed the facility determined Residents #2 and #5 required "Immediate Move-out." Interview with the Chief Operating Officer on January 31, 2012 at 9:00 a.m., in the ED's office revealed the was unable to provide the required care and confirmed the facility had insufficient staff to meet the needs of the residents.	D 716		
D 801	1200-08-25-.08 (1)(a) Admissions, Discharges, and Transfers (1) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any of the following conditions: (a) Requires treatment for stage III or stage IV decubitus ulcers or with exfoliative dermatitis; This Rule is not met as evidenced by: Based on medical record review, review of facility facsimile documentation, and interview, the facility admitted and permitted the continued stay of two residents (#9, #15) with Stage IV pressure ulcers of twenty residents reviewed. The findings included: Resident #9 was admitted to the facility on July 22, 2010 with diagnoses including Parkinson's Disease and Diabetes Mellitus. Medical record review of a Documentation of Face-to-Face Encounter signed by a physician and dated August 8, 2011 revealed, "...The encounter with the patient was in whole, or in part, for the following medical condition: Stage IV	D 801	D801 **Corrective action for residents affected:** Residents #9 and 15 were discharged from the facility. **Other Residents that could potentially be affected:** Skin condition reports were completed by Resident Service Director on all residents residing in the facility. The caregivers report any unusual condition of the skin to the Resident Service Director. The facility will not move in a resident with documentation of having stage III or IV pressure ulcers. If a resident is found to have a skin condition, an outside	

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D 801	Continued From page 45 wound L (left) heel with MRSA (methycillin resistant steph aureus- e multi-entiblotic resistant organism)...very debilitated - lives in Asst (assisted) Living." Medical record review of a Chart Note dated September 11, 2011 revealed, "Home Health Skilled Nursing visit for wound care of Stage IV...pressure ulcer..." Medical record review of a Chart Note dated October 10, 2011 revealed, "...Stage 4 pressure ulcer to left heel..." Medical record review of a Chart Note dated October 20, 2011 revealed, "...returned from Hospital ...this morning..." Medical record review of a Transfer and Discharge Record dated November 11, 2011 revealed "...Reason for Transfer:..non-compliant with meds (medications) and had wounds on...heels..." Review of a facility facsimile dated February 13, 2012 at 1:49 p.m. confirmed "(Resident #9) was admitted with a stage IV wound." Resident #15 was admitted to the facility on June 1, 2011 with diagnoses including Stage IV Pressure Ulcer. Medical record review of a Physician Statement dated June 1, 2011 revealed, "...can needs be satisfactorily met in a licensed facility providing 24 hour asssisted living - yes..." Medical record review of Resident Assessment dated June 6, 2011 and signed by the Resident Services Director revealed, "...Pressure Sore St IV (Stage 4)..." Medical record review of a Chart Note dated January 9, 2012 revealed the resident was transferred to a hosptial following difficulty obtaining a blood pressure reading. Medical record review revealed the resident had not	D 801	agency will be contacted to determine if it is a stage III or IV pressure ulcer. If residents are found to have a stage III or IV pressure ulcer, they will be transferred to another facility or we will find alternative housing to better meet their needs. The Resident Service Director or a licensed nurse completes a level of care assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home to ensure that resident's care needs are met and that the resident is able to be appropriate for Assisted Living. On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living.	

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D 801	Continued From page 46 returned to the facility. Review of an Acuity Discharge Planning form dated December 9, 2011 and provided by the Executive Director (ED) revealed "...Priority A (A=Immediate Move Out)...wound on coxic (coccyx)...staged a - stage 4..." Interview with the ED on February 7, 2012 at 2:15 p.m. in the marketing office confirmed sampled Resident #15 was admitted with a Stage IV pressure ulcer and the facility permitted the resident to stay in the assisted living facility with a Stage IV pressure ulcer until January 9, 2012. C/O: #28393	D 801	<u>Measures and systematic changes to prevent recurrence:</u> A licensed nurse will conduct skin condition reports upon move-in and throughout the stay. Skin condition reports were completed by Resident Service Director on all residents residing in the facility. The caregivers report any unusual condition of the skin to the Resident Service Director. The facility will not move in a resident with documentation of having stage III or IV pressure ulcers. If a resident is found to have a skin condition, an outside agency will be contacted to determine if it is a stage III or IV pressure ulcer. If residents are found to have a stage III or IV pressure ulcer, they will be transferred to another facility or we will find alternative housing to better meet their needs. The Resident Service Director or a licensed nurse completes a level of care assessment per our policy prior to move in, after 30 days,	
D 806	1200-08-25-.08 (1)(f) Admissions, Discharges, and Transfers (1) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any of the following conditions: (f) Has needs that cannot be safely and effectively met in the ACLF. This Rule is not met as evidenced by: Based on medical record review, review of a facility Acuity Discharge Planning report, review of a police report, observation, and interview, the facility failed to discharge and transfer residents whose needs could not safely be met for twenty-one residents (#2, #5, #6, #7, #8, #9, #24, #25, #28, #27, #28, #29, #30, #31, #32, #33, #34, #37, #38,#39, #40) of forty-two sampled residents. The findings included:			

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D 806	Continued From page 47 Resident #2 wes admitted to the facility on June 30, 2011 with diagnoses including Dementia. Review of an Acuity Discharge Planning report dated December 9, 2011 revealed the resident required care in a secure unit. Medical record review of a Chart Note dated December 24, 2011 revealed, "...discovered in room...bleeding from nose, ear, mouth, and jew appeared to be swelling...had beat (resident) with cane..." Review of a Police Report dated December 24, 2011 revealed, "...Victim (Resident #2)...aggravated assault...blunt object..." Telephone interview with Police Detective #1 on February 7, 2012 at 10:05 a.m. revealed Resident #2 had expired, an autopsy was performed, and complications of blunt force trauma was the cause of death. Resident #5 was admitted to the facility on September 11, 2009 with diagnoses including Pick's Disease. Review of an Acuity Discharge Planning report dated December 9, 2011 revealed, "...total care..." Medical record review of a Chart Note dated September 7, 2011 revealed "...was found on floor...hit...head...no redness or bruising..." Medical record review of Chart Notes dated December 11, 2011 revealed, "Took to room after lunch and resident slid out of chair and was on floor...gash on left side of head...to	D801	every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home to ensure that resident's care needs are met and that the resident is able to be appropriate for Assisted Living. Resident Service Director will monitor residents each month by completing one random skin condition check to ensure the skin condition reports are being completed accurately and will report findings to the Executive Director. This will be done for 3 months and will continue one time per month, every 3 months as per our policy. Care givers were in-serviced on skin care, March 29, 2012 by the Resident Service Director. This in-service included how to complete a skin condition report and what to report to the Resident Service Director.	

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D 806	Continued From page 48 hospitel...returned, spoke with Dr. (doctor) stated he put staples in...head..." Medical record review of an Emergency Provider Report dated December 11, 2011 revealed, "...fell out of wheelchair...1.5 cm (centimeter) lac (laceration)...non-ambulatory at baseline...non-communicative at baseline...stapled..." Observation on February 8, 2012 at 8:58 a.m. revealed Medical Technician (MT) #2 assisted the resident to an upright sitting position, held the resident in the upright sitting position, and the facility's Quality Services Manager administered medication to the resident. Continued observation revealed MT #2 physically lifted the resident and placed the resident onto the bed. Review of an Acuity Discharge Planning report dated December 9, 2011 provided by the Executive Director on February 7, 2012 revealed the facility determined twenty-six residents required "Immediate Move-out." Continued review revealed the following: Resident #2: needs secure unit Resident #5: Hospice; Total Care Resident #6: Total Care Resident #7: 104 years old; hospice; total care Resident #8: Non-embulatory; total care Resident #9: Wound on heel Resident #24: Total Care Resident #25: Non-ambuletory Resident #26: Non-amb (non ambulatory), two person transfer - Hospice Resident #27: Needs secure unit Resident #28: Total Care... Resident #29: Total Care... Resident #30: Two person tranfer	D801	The Resident Service Director completed skin condition reports on all residents March 29, 2012 through April 4, 2012. **Corrective Action:** Skin condition reports will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-1

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D 806	Continued From page 49 Resident #31: Confused; non-ambuletory Resident #32: Total Care Resident #33: Blind; Total Care Resident #34: Wenders; needs secure unit Resident #37: Total Care Resident #38: Confused; total care Resident #39: Non-ambulatory Review of a letter from the facility end deted January 18, 2012 revealed, "...Notice of Discharge and Transfer...(Resident #39)...has needs that cannot be safely and effectively met in the Community (assisted living facility)..." Review of letters from the facility end dated January 19, 2012 revealed, "...Notice of Discharge and Transfer...(Residents #8, # 24, #25, #26, #27, #28, #29, #30)...has needs that cannot be safely and effectively met in the Community..." Review of letters from the facility and dated January 20, 2012 revealed, "...Notice of Discharge and Transfer...(Residents #34, #40)...Notice of Discharge and Transfer...hes needs that cannot be safely and effectivety met in the Community..." (The Discherge Acculty Planning Report deted December 9, 2011 did not include Resident #40.) Review of the facility's current census dated January 30, 2011 revealed eighteen of the residents identified by the facility in the report dated December 9, 2011 remained in the facility (#5, #6, #7, #8, #11, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #37, #38, #39).	D 806	D806 Corrective action for residents affected: Residents #2,5,6,7,8,9,24,25,26,27,28,29,30, 31,32,34,37,38 and 39 have been discharged from this facility. Number 33, 40 and 11 are in the process of discharge. Other Residents that could potentially be affected: Per the Elmcroft policy, residents will be provided sufficient staff to meet their needs. As stated in the regulations, 1200-08-25-.12 under Resident Records, page 32 number 4; An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy two (72) hours after admission; however in all reasonable opportunities a licensed nurse conducts the assessment per our policy. It is not acceptable practice for a Community Relations Director to	

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D 806	Continued From page 50 Interview with the Executive Director (ED) on Jenuary 30, 2012, revealed the facility was in the process of moving some residents from the second floor to the first floor to improve evacuation time. Interview with the Chief Operating Officer (COO) on Januery 31, 2012 et 9:00 a.m. in the Executive Director's office revealed, "...facility has twenty-two residents on e list to discharge to more appropriate level of care...we considered closing this...(facility) because things were so bad." Interview with the EO on February 1, 2012 et 2:10 p.m. revealed the facility was acquired by a new owner on August 1, 2011; she begen as ED during the last week of October, 2011 and she stated, "...The first couple of deys some residents were inappropriately placed and began process of notifying families...created acuity log. We had to put together a letter to notify residents/families of need to move to another level of acuity...by early part of Oecember, 2011 residents were essessed on our level of care assessment and service plans driven by that...We knew from (acuity log dated December 9, 2011) (on) January 17 (2012) who would need to go..." Telephone interview with the Senior Vice President of Resident Services on February 1, 2012 at 2:40 p.m. revealed, "...Facility has been hended years of issues. (Facility) went through assessment who's appropriate and who's not appropriate...only so much we could do so quickly..." Interview with the Chief Operating Officer (COO) on Jenuery 31, 2012 at 9:00 e.m. in the ED's office confirmed the facility had failed to	D 806	conduct an assessment. A licensed nurse does an assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home dependent upon the residents needs as determined by the level of care assessment. On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living.	

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D 806	Continued From page 51 discherge residents the facility had determined required care the facility could not provide. He stated, "...facility has twenty-two residents on list to discharge to more eppropriate level of care. This is not our standerd of care..." Interview with the COO on February 10, 2012, at 2:30 p.m. in the merketing office revealed "...if the state is going to close us would like it to be sooner than later..." C/O: # 28393	D 806	Measures and systematic changes to prevent recurrence: The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by the Quality Service Manager to monitor the Resident Services Director and Executive Director . This meeting is to ensure the facility can meet the acuity levels of the residents. A Resident Service Coordinator position was added on February 16, 2012 to be responsible for scheduling with a primary focus of staffing. The staffing is determined by the number of residents being serviced and their individual care plan needs. The Resident Service's Coordinator reports directly to the Resident Service Director. The Resident Service Director will review a sample of the care plan's one time per week for the next 6 weeks and ongoing as needed. The Executive Director and Resident Services Director check	
D 901	1200-08-25-.09 (1) Building Standards (1) An ACLF shall construct, arrange, and maintain the condition of the physical plant and the overall ACLF living facility environment in such e manner thet the safety end well-being of residents are assured. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to meintain the physicel condition of the overall ACLF (Assisted Cere Living Facility) environment for the safety of both residents and staff. The findings included: Observation on February 12, 2012 et 11:30 e.m. revealed a penetration around the smoke detector within room 242 'A'. The finding was acknowledged by the Administrator and verified by the Maintenance Director during interview on 2/2/12. C/O #28393			

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		D806	the staffing model to ensure it is sufficient to meet the acuity needs of the residents. Labor hours are reviewed Monday through Friday with Executive Director, Resident Service Coordinator and Resident Service Director to ensure adequate staffing is utilized. This system is monitored weekly by reporting during the regional operations call with the Regional Director of Operations and Quality Service Manager **Corrective Action:** The level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home, and labor hours will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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	LSC	D901	901 Corrective action for residents affected: The penetration around a smoke detector within room 242A has been corrected. Other Residents that could potentially be affected: The Maintenance Director has checked the building for penetrations and will continue on the preventative maintenance monthly checks. Measures and systematic changes to prevent recurrence: The Maintenance Director checks for penetrations in the facility during monthly preventative maintenance checks and reports findings to the Executive Director. The Executive Director does spot checks weekly during facility rounds to ensure there are no penetrations.	

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	LSC	D901	**Corrective Action:** The penetration tracking will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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D1001	1200-08-25-.10 (1) Life Safety (1) The department will consider any ACLF that complies with the required applicable building and fire safety regulations at the time the Board adopts new codes or regulations, so long as such compliance is maintained (either with or without waivers of specific provisions) to be in compliance with the requirements of the new codes or regulations. This ELEMENT is not met as evidenced by: Based on observation and interview, the facility failed to comply with applicable building and fire safety regulations. The findings included: Observation during the fire drill on 2/2/12 at 10:24 AM, revealed one of each of the double doors on the North West and the South East halls did not open in the direction of travel, while the same doors could each be opened from the other direction. This finding was acknowledged by the Administrator and verified by the Maintenance Director during interview on 2/2/12. C/O: #28393	D1001	**D1001** **Corrective action for residents affected:** The double doors on the North West and South West halls have been corrected to ensure they open in the direction of travel. **Other Residents that could potentially be affected:** The Maintenance Director has checked the fire doors throughout the facility to ensure they open in the direction of travel. **Measures and systematic changes to prevent recurrence:** The Maintenance Director checks fire doors during monthly preventative maintenance checks and reports findings to the Executive Director. **Corrective Action:** The fire door tracking will be reviewed by the Quality Assurance Committee consisting of the	
D102	1200-08-25-.10 (5)(c) Life Safety (5) An ACLF shall take the following precautions regarding electrical equipment to ensure the safety of residents: (c) Maintain all electrical equipment in good			

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	TNPL53766	A. BUILOING _____ B. WING _____	C 03/01/2012

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MAOISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE DATE
D1024	Continued From page 53 repair and safe operating condition; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain call lights in safe operating condition for three residents (#21, #22, #23) of thirteen resident call lights observed and failed to maintain the electrical equipment. The findings included: Observation with the Maintenance Director on February 1, 2012 between 10:50 a.m. and 11:02 a.m. revealed a bathroom call light and two of two call lights over residents' beds in Room 235 did not function. Continued observation revealed a bathroom call light and an overbed call light in Room 237 did not function. Interview with Medication Technician (Med Tech) #1 on February 1, 2012 at approximately 10:51 a.m. in a second floor corridor revealed a pager in the Med Tech's possession sounded when a bathroom call light was utilized and the pager recorded calls. Continued interview revealed the light had not sounded, and observation and interview confirmed the pager had not recorded the call from Room 235. Interviews with the Maintenance Director on February 1, 2012 at approximately 11:00 a.m. and 11:04 p.m. in a second floor corridor confirmed the call lights were not in safe operating condition. On 2/2/12 at 11:45 AM, observation within resident rooms 209, 232, 242 245 and 256	D1024	Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly. **O1024** **Corrective action for residents affected:** Residents #21, 22, and 23's call lights have been repaired and are functioning properly. Lens covers for the light fixtures in rooms 209, 232, 242, 245, and 256 have been repiaced. **Other Residents that could potentially be affected:** The Maintenance Director checked light fixtures throughout the building to ensure they had lens covers in place on March 28, 2012.	

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	TNPL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

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ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MADISON, TN 37115

(X4) ID PREFIX TAO	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1024	Continued From page 54 revealed the lens covers for the light fixtures were missing. The findings were acknowledged by the Administrator end verified by the Maintenence Director during interview on 2/2/12. C/O: #28393, #28241, #29088	D1024	The Maintenance Director will check light fixtures monthly to ensure they have lens covers and report findings to the Executive Director. **Corrective Action:** The lens cover tracking will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	
D1035	1200-08-25-.10 (8)(a) Life Safety (8) An ACLF shall ensure thet: (a) The ACLF maintains ell safety equipment in good repair and in a safe operating condition; This Rule is not met as evidenced by: Based on observation, testing, and interview, the facility failed to meintain the safety equipment. The findings included: Observation during the fire drill on 2/2/12 at 10:35 a.m. reveeled the fire alarm strobes were not synchronized. On 2/2/12 at 11:33 AM, testing of the smoke detector in room 242 B revealed the unit was not working. These findings were acknowledged by the Administrator and verified by the Meintenance Director during interview on 2/2/12. C/O: #28393	D1035	**D1035** **Corrective action for residents affected:** The fire alarm strobes will be synchronized by an outside contractor by March 30, 2012. The smoke detector in room 242B has been replaced.	
D1045	1200-08-25-.10 (10)(f) Life Safety			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
		D1035	**Other Residents that could potentially be affected:** The Maintenance Director has checked the smoke detectors in resident rooms to ensure they are working properly. **Measures and systematic changes to prevent recurrence:** The Housekeepers check daily during room cleaning for equipment in proper working order to include the light fixtures. The Maintenance Director reviews the daily check off sheets for compliance. The Maintenance Director will review findings with the Executive Director. **Measures and systematic changes to prevent recurrence:** The strobes will be checked monthly during a fire drill for proper working order and findings will be reported to the Executive Director.	

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	TNPL53766	A. BUILDING _____ B. WING _____	C 03/01/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
		01035	The smoke detectors will be checked by the Maintenance Directory monthly during preventative maintenance rounds and findings will be reported to the Executive Director. **Corrective Action:** The strobes and smoke detectors will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12
		01045	**01045** **Corrective action for residents affected:** Air return grilles and air supply diffusers will be cleaned and in compliance no later than 3-30-2012.	

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D1045	Continued From page 55 (10)An ACLF shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following: (f) Maintain the building and its heating, cooling, plumbing and electrical systems in good repair and in clean condition at all times; and LSC This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building and heating system in good repair and in clean condition. The findings included: On 2/2/12 at 11:45 AM. observations within the facility revealed the air return grilles and air supply diffusers were dirty. This finding was acknowledged by the Administrator and verified by the Maintenence Director during interview on 2/2/12. C/O: #28393	D1045	**Other Residents that could potentially be affected:** Air return grilles and air supply diffusers will be cleaned and in compliance no later than 3-30-2012. **Measures and systematic changes to prevent recurrence:** The Maintenance Director will have housekeeping maintain the air return grilles for cleanliness daily. The Maintenance Director will monitor compliance and report findings to the Executive Director. **Corrective Action:** Air return grilles tracking will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12
D1206	1200-08-25-.12 (2)(e) Resident Records (2) Personal record. An ACLF shall ensure that the resident's personal record includes at a minimum the following: (e) Date of admission, transfer, discharge and any new forwarding address; This Rule is not met as evidenced by: Based on medical record review, interview, and review of facility facsimile documentation, the facility failed to document the date of admission			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1206	Continued From page 56 for one resident (#4) of twenty residents reviewed. The findings included: Medical record review (Resident #4) of a Personal Data and Contact Sheet revealed the date of admission was blank. A request for documentation for Resident #4's date of admission was made to the facility's Quality Services Manager on February 10, 2012 at 12:02 p.m. Interview with the Quality Services Manager on February 12, 2012 at 12:02 p.m. in the Marketing Office revealed the requested documentation would be faxed to the State Agency. Review of facsimile (fax) documentation provided by the facility on February 13, 2012 at 1:49 p.m. confirmed the facility failed to include the resident's date of admission on the resident's Personal Data and Contact Sheet and included, "...Date of admission: unable to find..."	D1206	**D1206** **Corrective action for residents affected:** Resident #4 has been discharged from the facility to a higher level of care. The admission date was obtained on March 29, 2012 by the Executive Director for this resident and added to the file as an addendum. **Other Residents that could potentially be affected:** The resident information sheet for new move-ins prior to or on the date of move-in to include the state required information, such as admission and discharge/transfer dates and any new forwarding addresses will be completed by April 10, 2012. Current residents have a resident information sheet in their Resident care chart. The Elmcroft standard of organized files will be followed. The current resident records will be reorganized in chronological order per Elmcroft standards by April 10, 2012.	
D1212	1200-08-25-.12 (3)(c) Resident Records (3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum: (c) Orders and recommendations for all medication, medical and other care, services, procedures, and diet from physicians or other authorized healthcare providers, which shall be completed prior to, or at the time of admission,			

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		D1206	Measures and systematic changes to prevent recurrence: The resident information sheet for new move-ins is done prior to or on the date of move-in to include the state required information, such as admission and discharge/ transfer dates and any new forwarding addresses. The Community Relations Director will complete the resident information sheet prior to or on the date of move-in as per the policy. The Executive Director will monitor for compliance by doing random monthly audits to include at least 2 charts per month. The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by the Quality Service Manager to monitor the Resident Services Director and Executive Director. This meeting is to ensure the facility can meet the acuity levels of the residents and includes	

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D1212	Continued From page 57 and subsequently, es warranted. Verbal orders received shall include the time of receipt of the order, description of the order, and identification of the individuel receiving the order; This Rule is not met as evidenced by: Based on medical record review, review of fecility facsimile documentation, and interview, the facility failed to maintain e medicel record to include physician's order to trensfer to a hospital for eveluation/treatment for five residents (#1, #2, #3, #5, #15) of twenty residents reviewed. The findings included: Resident #1 was admitted to the facility with diagnoses including Dementia and Degenerative Joint Disease. Medical record review of e Chart Note dated December 11, 2011 revealed, "...fell hit L (left) side of head...transported to...Hospital." Medical record review revealed no documentation regarding a physician's order to transfer the resident to the hospital. Interview with the Resident Services Director on January 30, 2012 at 12:20 p.m. In the marketing office, confirmed the facility failed to obtain orders to transfer the resident to a hospital on December 11, 2011. Resident #2 was admitted to the facility on October 12, 2010 with diagnoses including Dementia. Medical record review of a Chart Note dated December 24, 2011 at 10:00 p.m. revealed, "Resident discovered by care attendant...was	D1206	tracking information for the new move-in's and move-out's. Corrective Action: The resident information sheet and at risk tracking information will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly. D1212 Corrective action for residents affected: Residents #1, 2, 3, S and 1S have been discharged from the facility. Dther Residents that could potentially be affected: Physician's orders are now obtained to transfer residents to the hospital.	4-10-12

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D1212	Continued From page 58 bleeding from nose, ear, mouth, and jaw appeared to be swollen...Resident sent to ER (Emergency Room)..." Medical record review revealed no documentation regarding a physician order to transfer the resident to the hospital. Interview with the Quality Service Manager on February 10, 2012 at 11:47 a.m. in the marketing office, confirmed the facility failed to obtain a physician's order to transfer the resident to the hospital on December 24, 2011. Resident #3 was admitted to the facility with diagnoses including Hypertension and Parkinson's Disease. Medical record review of a Chart Note dated June 18, 2011 revealed, "(Resident) was sent out to Hospital do (due) to fall..." Medical record review revealed no documentation regarding a physician's order to transfer the resident to the hospital. Interview with the Resident Services Director on February 1, 2012 at 9:30 a.m. in the Executive Director's office, confirmed the facility failed to obtain a physician's order to transfer the resident to a hospital on June 18, 2011. Resident #5 was admitted to the facility on September 9, 2011 with diagnoses including Pick's Disease. Medical record review of a Chart Note dated December 11, 2011 revealed, "...slid out of chair and was on floor...gash on left side of back of head...to (hospital)..." Medical record review revealed no documentation regarding a	D1212	The Elmcroft policy will be followed to complete the Physician's Plan of Care for new resident admissions prior to or on the date of the admission. This is completed by the Resident Service Director. Measures and systematic changes to prevent recurrence: The Resident Service Director in-serviced staff on obtaining a physician's order to transfer residents to a hospital March 20, 21 and 22, 2012. Current residents have a physician's plan of care with a standing order to transfer resident to the hospital in the event of an emergency. The physician's plan of care will be tracked by monthly audits of medical records to ensure they are in compliance. Corrective Action: The physician's plan of care audits will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident	

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D1212	Continued From page 59 physician's order to transfer the resident to the hospital. A request for documenfation regarding a physician's order was made to the facility's Quality Services Manager on February 10, 2012 at 12:08 p.m. Review of facsimile (fax) documentation provided by the facility and dated February 13, 2012 at 1:49 p.m. confirmed the facility failed to obtain a physician's order and included, "...no order to transfer out due to fall..." Resident #15 was admitted to the facility on June 1, 2011 with diegnoses including Stage IV Pressure Ulcer. Medical record review of a Chart Note dated January 9, 2012 revealed, "...having difficulty obtaining blood pressure...transported to (hospital)..." Medical record review revealed no documentation regarding a physicien's order to transfer the resident to a hospital. Interview with the Executive Director (ED) on January 31, 2012 at 11:55 a.m. in her office revealed she was unaware a physician's order was required to transfer an ecutely ill or injured resident to a hospital. Continued interview confirmed the facility failed to ensure medical records included physician's orders for Residents #1, #2, #3, #5, and #15.	D1212	Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12
D1222	1200-08-25-.12 (4) Resident Records (4) An ACLF shall complete a written assessment of the resident to be conducted by a	D1222		

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D1222	Continued From page 60 direct care staff member within e time-period determined by the ACLF, but no later then seventy-two (72) hours efter admission. This Rule is not met es evidenced by: Based on medical record review, review of facility facsimile documentetion, and interview, the facility failed to timely complete e written assessment for sixteen residents (#1, #3, #4, #5, #6, #7, #6, #9, #10, #11, #12, #13, #14, #15, #16, #19) of eighteen residents reviewed. The findings included: Medical record review revealed no documentation regarding written assessments within seventy-two hours of admission for Residents #1, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16 and #19. Interview with the Resident Services Director (RSD) on January 30, 2011 at 12:20 p.m. in the Executive Director's (ED) office confirmed the facility failed to complete an assessment for Resident #1. Interview with the RSD on Februery 1, 2012 at 9:30 a.m. in the ED's office confirmed the facility failed to complete an assessment for Resident #3. Requests for documentation regarding assessments for Residents #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #16, and #19 were made to the facility's Quality Services Menager (QSM) on February 10, 2012 between 12:08 p.m. end 1:12 p.m. Interview with the facility's QSM on February 10,	D1222	D1222 Corrective action for residents affected: Resident's #1, 3, 4,5,6,7,8,9,13,14 and 15 have been discharged from the facility. Resident's #10, 11, 12, 16 and 19 have a written assessment that is current per the Per the Elmcroft policy, residents will be provided sufficient staff to meet their needs. As stated in the regulations, 1200-08-25-.12 under Resident Records, page 32 number 4; An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy two (72) hours after admission; however in all reasonable opportunities a licensed nurse conducts the assessment per our policy. It is not acceptable practice for a Community Relations Director to conduct an assessment. A licensed nurse does an assessment per our policy prior to move in, after 30 days, every 6 months or upon a change of condition or return from	

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D1222	Continued From page 61 2012 between 12:33 p.m. and 1:12 p.m. In the marketing office confirmed the facility failed to complete assessments for Residents #9 and #12. Review of facsimile documentation provided by the facility on February 13, 2012 at 1:49 p.m. confirmed the facility failed to complete assessments for Residents #4, #5, #6, #7, #8, #10, #11, #13, #14, #15, #16, and #19. C/O: #29068	D1222	an alternative setting such as, hospital, rehab/skilled care or home dependent upon the residents needs as determined by the level of care assessment. On March 8, 2012, all existing residents were assessed by licensed nurse per the policy to ensure their appropriateness for Assisted Living. <u>Measures and systematic changes to prevent recurrence:</u> The facility has weekly at risk calls which are designed to discuss the resident Quality Services as documented on a log, driven by	
D1223	1200-08-25-.12 (5)(a) Resident Records (5) Plan of care. (a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident's legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals. This Rule is not met as evidenced by: Based on review of the resident census and interview, the facility failed to develop a plan of care for twenty residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #16, #19, #20) of twenty residents reviewed. The findings included: Review of the resident census dated January 30, 2012 revealed sixty-nine residents currently resided in the facility and four residents were in a			

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		D1222	the Quality Service Manager to monitor the Resident Services Director and Executive Director. This meeting is to ensure the facility can meet the acuity levels of the residents **Corrective Action:** The level of care assessment which is completed prior to move in, after 30 days, every 6 months or upon a change of condition or return from an alternative setting such as, hospital, rehab/skilled care or home will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF TWIN HILLS	94 TWIN HILLS DRIVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1223	Continued From page 62 hospital or a rehabilitation facility. Interview with the Resident Services Director (RSD) on February 2, 2012 at 12:20 p.m. In the Executive Director's office revealed the RSD determined a resident's needs and communicated those needs to the staff. Continued interview reveeled care plans had not been developed for any resident. Interview with the Quality Services Manager on February 10, 2012 at 12:02 p.m. In the marketing office confirmed the facility failed to develop a plan of care for twenty of twenty residents. Continued interview confirmed the facility failed to develop a plan of care for eny resident within the facility.	D1223	**D1223** **Corrective action for residents affected:** Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 13, 14, and 15 have been discharged from the facility. Residents #10, 11, 12,16,17,18 and 19 currently have a plan of care in the resident's medical record. **Other Residents that could potentially be affected:** Plan of care documentation has been completed on each resident per Elmcroft policy. This was completed by the Resident Service Director on March 29, 2012. This is called the service plan and is completed by each shift. **Measures and systematic changes to prevent recurrence:** The service plan is checked by the licensed nurse or supervisor of the shift to ensure assignments are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53768	A. BUILDING _____ B. WING _____	C 03/01/2012

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		D1223	properly being carried out. This information is reported to the Resident Service Director. The Resident Services Director completes the service plan for each resident upon move-in, by using the level of care assessment to determine the services needed. The service plan indicates the services required, and the methodology in completing the task specific to the individual resident. **Corrective Action:** The service plans will be reviewed by the Quality Assurance Committee consisting of the Executive Director, Resident Services Director, Resident Services Coordinator, Maintenance Director, Dining Services Director, Business Office Coordinator and Healthy Lifestyles Director, monthly.	4-10-12